

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005056</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/26/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>DAVIESS COMMUNITY HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1314 E WALNUT ST WASHINGTON, IN 47501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of a State complaint.</p> <p>Complaint #IN00160974 Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey date: February 27, 2015</p> <p>Facility # 005056</p> <p>Surveyor: Trisha Goodwin, RN BSE Public Health Nurse Surveyor</p> <p>Daviess Community Hospital is in compliance with 410 IAC 15-1.5-5; Medical Staff</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE